Mercy Medical Center Strategic Hospital Transformation Plan

December 7

2015

During its June 2015 public meeting, the Health Services Cost Review Commission (HSCRC) approved a requirement that all acute care hospitals in the State to submit a plan to the Commission by December 7, 2015 summarizing their short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers. The required plan is now referred to as the Strategic Hospital Transformation Plan and is intended to the broad strategic plan of the hospital toward these goals. Attached is Mercy Medical Center's Strategic Hospital Transformation Plan.

For the Health Services Cost Review Commission

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EXECUTIVE SUMMARY:

Under the new All Payer Model Mercy Health Services (MHS) continues improving quality, lowering costs and responding to population/community needs. Through Global Budget Revenue (GBR) incentives, Mercy has broadened its focus and reached further into the community to work towards Maryland's statewide population health goals. The HSCRC Strategic Hospital Transformation Plan requirement is aligned with Mercy's own strategic plan initiative to *methodically transform MHS into a patient-centered, integrated system delivering high value care.*

MHS is a leader in quality and patient experience, reducing potentially avoidable utilization, and generating Medicare savings through the successful CareFirst Patient Centered Medical Home (PCMH) pilot. Our recent achievements include:

- **Top Performer—Potentially Avoidable Utilization (PAU):** Since January 2013, Mercy Medical Center (MMC) has ranked no less than second for acute care hospitals statewide with the least PAU (See Appendix 1 - PAU as a percentage of Total Charges).
- **Top Performer—Quality & Patient Experien**ce: Medicare has rated Mercy Medical Center the number one hospital in the state for Patient Experience as the only Maryland hospital to currently achieve a Four-Star rating for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey performance.
- **Top Performer—PCMH Medicare Savings:** By participating in the CareFirst's PCMH program, MHS primary care physicians saved Medicare $11,273,180 in 2014 and saved commercial $8,374,506 (See Appendix 2)**.** MHS panels were top performers in this program and the Medicare savings represented more than 40% of the total statewide PCMH savings in the pilot. However, because MHS primary care practice panels are located in Lutherville & Overlea, in closer proximity to other hospitals, much of the PCMH-related utilization savings from avoided hospital admissions and ER visits under GBR accrued to those hospitals, not Mercy Medical Center (particularly UM St. Joseph Medical Center, Greater Baltimore Medical Center, and MedStar Franklin Square).

Mercy generates more than sixty percent (60%) of its revenue from regionally oriented, surgically focused specialty programs (Centers of Excellence) (See appendix 3) **while also maintaining an array of specialized citywide support programs for pregnant women, homelessness, substance abusers (Inpatient Medical Detoxification Unit), and Federally Qualified Health Centers**). Mercy also houses the Sexual Assault Forensic Examination program (SAFE) and domestic violence program (FVRP).

Mercy has reduced its population of high utilizers through highly effective readmission reduction and extended care activities. Mercy knows its high risk population including individuals experiencing homeless (proximity driven), end stage liver disease (program driven) and high risk mothers. Mercy has tailored specific interventions for these target populations.

Mercy is significantly challenged by low birth weight babies and high risk pregnancies and needs support for interventions with maternal health. While not tied to Medicare utilization reduction efforts, rising medical liability risk costs could impact Maryland's success in meeting the cost growth and quality requirements under the All Payer Model. Mercy is an essential provider as the largest hospital obstetrical program in Baltimore City delivering 3,078 babies for the twelve month period ending November 30, 2015. Approximately sixty-nine percent (69%) of the mothers participate in the Maryland Medicaid program. Mercy's goal is to reduce low birth weight babies associated with the higher risk population.

Mercy has long-standing, and strong, community partnerships with Federally Qualified Health Centers (FQHC's). FQHC's fill a vital role in the community and our partnerships emphasize cooperation in caring for patients rather than competition. We are focused on collective learning, leveraging our respective strengths, and specific initiatives to improve community health. Mercy specifically maintains active partnerships with Health Care for the Homeless, Family Health Centers of Baltimore, Total Health Care and Park West Medical Center to help manage high risk populations including pregnant women. Ms. Faye Royale-Larkins, Chief Executive Officer, Total Health Care serves on the MHS Board of Directors. MHS executives or physician leaders serve on the Boards of Total Health Care, Family Health Centers of Baltimore, Health Care for the Homeless and Park West Medical Systems.

Mercy has also been an active participant in three (3) regional hospital collaboratives during calendar 2015: Due to Mercy Medical Center's downtown location between other larger hospitals we are not the dominant hospital provider for the targeted population (Medicare high utilizers) in any Baltimore City zip codes (See Appendix 4)**.** Therefore, Mercy is collaborating with John Hopkins Regional Partnership (JHRP), West Baltimore Collaborative (WBC) and Advanced Health Collaborative (AHC). Joint strategies are outlined in this plan and other strategies will appear in the regional partnership reports. Given limited resources we expect to narrow our collaborative participation in calendar year 2016 and focus on the John Hopkins Regional Partnership and West Baltimore Collaborative.

MHS 2016 Population Health Strategies

Mercy will build on its successful 2014-15 strategies. A hospital stay provides a critical opportunity to identify and interact with high-risk/high need patients to prevent future hospitalizations. **Central to Mercy's success in managing complex patients and reducing potentially avoidable utilization is a centralized care management infrastructure.** Mercy will continue to build its core care management capabilities in 2016 and pursue additional strategies alone and/or in collaboration with other hospitals, FQHCs or payer partners. Mercy's complex care coordination and improvement activities include:

- Risk stratification of the population
- A focus on patients with a **high risk diagnosis**
- A bedside medication delivery at discharge program
- Intensive education for patients and families through the Get Well Network
- Timely communication with primary care providers (PCP) and connecting patients without primary care physicians to PCP's in the community (including Obstetricians)
- Extended care activities by a physician-led population health team including a post acute clinic for post-discharge needs, scheduling or checking on follow-up appointments.
- Expedited charity care policy to speed transitions home or to lower cost settings.
- Care coordination across settings

Mercy will continue participation in CareFirst's Patient-Centered Medical Home (PCMH) Medicare pilot, providing it is renewed**.** The PCMH model has proven to be an effective approach to engaging patients and physicians to improve population health and lower cost.

Mercy has also invested considerable time and funds into IT connectivity. We implemented EPIC Ambulatory Electronic Health Record (EHR) for our physician network and hospital outpatient clinics. We are currently evaluating an upgrade of our inpatient EHR platform and expect to make substantial investments over the next 3 years. Mercy is also participating in the Regional Community Health Partnership Information Technology Taskforce and identified areas where care coordination can be enhanced with additional funding. Foremost in our mind is creating systems that facilitate information sharing and communication between clinicians, hospitals, and community based organizations.

Hospital Strategic Transformation Plan

1. Overall goals:

MHS is committed to improving population health, improving quality and patient experience, and reducing cost. Our 2016 goals include:

- Reducing the cost of care by achieving further reductions of potentially avoidable utilization with a focus on Medicare high utilizers.
- Improving population health by increasing supports for PCP's management of complex/high risk and rising risk populations
- Improving population health by increasing community health center capacity to manage complex/high risk pregnancies
- Improving population health by improving the integration of physical and behavioral health services

2. Major Strategies:

Mercy 2016 Population Health Strategies: In 2016 Mercy will pursue the following strategies alone and/or in collaboration with other hospitals, FQHCs or payer partners:

1. Improving complex/chronic care management by expanding Mercy Population Health team activities (pre-discharge and extended care) and enhancing support to primary care providers in conjunction with the JHRP and WBC.
2. Improving pre-acute solutions by increasing case management/Social Worker (LCSW) capacity in the Emergency Department for homeless, substance abuse and psychiatric patient population, in conjunction with the JHRP
3. Improving care to the substance abuse and mental health population by collaborating on a multi hospital Behavioral Health "Bridge Team" with the JHRP
4. Improving care management of high risk pregnancies in the community setting through embedded case managers in community health centers (FQHC's)
5. Improving complex/chronic care management by expanding the Patient-Centered Medical Home model in partnership with CareFirst.

Strategy #1

Extend Population Health Management and PCP Support to Surgical Populations:
Mercy's 2014-15 efforts focused on managing the high risk/high need medical population. This initiative will expand care transitions and complex care management to surgical population by building on existing care management experience, expertise and infrastructure. A hospital stay provides a critical opportunity to identify and interact with high-risk patients to prevent future hospitalizations. MMC's centralized care management infrastructure employs an array of interventions to improve provider communication, patient and family education, care transitions from the hospital, and follow-up ambulatory care. Interventions span hospital, primary care, post-acute care and home care to help patients and families overcome barriers to effective care.

The multi level team for coverage of clinical, non clinical patient needs includes:

- Medical Director
- Advanced practitioner – PA-C
- Non clinical care facilitators providing
    - Patient Social Assistance
        - Transport arrangement
        - Appointment reminders
        - Community health resources
        - Caregiver assistance
    - Non Clinical Home Services
        - Durable Medical Equipment ordering
        - Medical device replacement
        - Home care services
        - Meals on wheels
    - Resource Coordination
        - Maintains list of community resources
        - Maintains relationships with community organizations

The Medical Director, an internist, has overall responsibility for the care management team. The Medical Director supervises midlevel practitioner(s) who directs a team of non clinical care facilitators and who consults and intervenes directly as needed.

An early action item of the team is to ensure that individuals in the target population have established linkages with a primary care physician. If they do not, the team connects patients to PCP's (estimated at 30%). Once a primary care physician linkage is established the team engages the PCP, developments one care plan and supports the patient and the PCP to address barriers to optimal care until patient can be successfully transitioned to the PCP. Once the care plan is established it is published and disseminated via CRISP. The team uses CRISP for ongoing daily monitoring of the targeted population, and follows up with involved providers. Core care improvement and coordination activities include:

- A focus on patients with a **high risk diagnosis**
- Bedside Medication at Discharge
- Patient Education through the Get Well Network
- Application of MHS charity care to expedite transitions home or to lower cost settings
- Efficient, timely and regular communication with the PCP
- A Physicians Assistant collaborating with hospital staff and the patient's PCP to develop a care plan, follows-up on non-clinical barriers with the PCP after hospital discharge to help prevent readmissions.
- This includes facilitation of evaluation, referrals, for substance abuse and psychiatric care, timely clinic follow-up, a follow-up call with the patient, and home visits.
- Reviewing, monitoring, and following adherence to appointments, medications, utilization of ED – particular focus on adherence with treatment recommendations, primarily medication adherence

- Tracking the patients after hospital encounter to ensure the patients are connected to PCP and the PCP can manage care.

In conjunction with transformation implementation awards, care facilitator coverage will be expanded to enhance care coordination and strengthen individual PCP and FQHC infrastructure. The population health team will also extend the PCP/patient follow up time to ensure effective long term management of the high risk/high need patient. Time will be spent in practices, visiting patients, and otherwise engaging patients depending on needs and site issues.

Target population:
Metrics: High risk diagnosis patients with early emphasis Medicare high utilizers. Medicare high risk/high utilizers defined as ≥ 3 bedded admissions.

Care Outcomes: (Baseline vs Each Year of intervention)
- Number of high utilizers
- Cost of care (Total charges)
- Emergency Department visits
- Admissions
- Observations stays
- Total hospital days

Care Management Process Measures:
- Engagement Rate: Percent of high utilizers not engaged with PCP who become engaged
- Number of encounters with Care Facilitators – by site
- Number of encounters with other program staff – by site
- Number of recommended for treatment re-evaluation

Partners:
Federally Qualified Health Centers including Health Care for the Homeless, Family Health Centers of Baltimore, Total Health Care, and Park West Medical Center to engage patients and facilitate treatment goals, non-FQHC PCP's and staff, Population Health Management staff of Johns Hopkins Regional Partnership and West Baltimore Collaborative.

Sustainability:
Potentially avoidable utilization (PAU) achievements to date can be sustained with the current infrastructure funding. Extension of the program to additional populations, and further achievements in PAU will be facilitated by award funding and sustained by building this into the total cost of care.

Strategy #2

Expand Emergency Department Capacity for Behavioral Health and Complex Care Intervention.

In conjunction with regional partner award(s), complex care management and clinical social work coverage will be expanded to increase hours and depth of coverage. An emergency department visit provides a critical opportunity to identify and interact with high-risk patients and prevent future visits. The Mercy population health team works to make connections with high risk/high need patients and provide care in the lowest cost, medically appropriate setting. This includes determining the patients PCP or usual source of care, assessing barriers to care and connecting patients to HealthCare for the Homeless, Family Health Centers of Baltimore, Health Care Access Maryland, Baltimore behavioral Health Systems and pregnant women presenting to Mercy ER to several FQHC's for prenatal services, healthy and safe births at Mercy and surrounding hospitals.

With the support of a regional partnership awards, care facilitator coverage (LCSW), coverage will be expanded to support for substance abuse and psychiatric referrals and as well as connections to community services like Health care for the Homeless.

Target Population:

Fifty two percent (52%) of Mercy's high utilizers (all-payers) have a mental health or substance abuse diagnosis. Seven percent (7%) have 6+ chronic diagnoses and twenty two percent (22%) have 4-5 chronic conditions. High utilizers with multiple chronic conditions and/or a mental health or substance abuse diagnosis are the target population.

Metrics:

Reduction in ED admissions for patients with ≥ 4 chronic conditions or Mental Health /Substance abuse diagnosis.

Partners:

Baltimore Behavioral Health System, Health Care for the Homeless, Family Health Centers of Baltimore, Total Health Care and Park West Medical Center currently work together to manage high needs populations including pregnant women. Our work will be enhanced with the creation of the JHRP Behavioral Health Bridge Team.

Sustainability:

Extension of the strategy to more of the targeted population and further achievements in PAU will be facilitated by additional staff at this access point through award funding. The benefits can be sustained by building these supports into the total cost of care.

Strategy #3:

Behavioral Health Bridge Team (JHRP)
This strategy, with the John Hopkins Regional Partnership, involves creating a multidisciplinary resource that works with patients exhibiting complex psychiatric needs, Substance Use Disorder (SUD), and other complex case management needs associated with behavioral health.

The goal of the team is to facilitate a successful transition to a long-term patient-centered medical home and effectively engage this targeted population in behavioral health services. The team provides a bridge to higher intensity mental health/addiction services such as psychotherapy, medication management, and intensive outpatient treatment. The Behavioral Health Bridge team is made up of a Psychiatrist, a lead Social Worker (LCSW), and community care team's PCP, and Case Manager.

The Behavioral Health Bridge Team is a shared resource and provides services to the hospitals in the regional partnership. The team also takes referrals from Emergency Departments, Acute care, PCP offices.

Target Population:
Fifty two percent (52%) of Mercy's high utilizers (all-payers) have a mental health or substance abuse diagnosis. High utilizers with a mental health or substance abuse diagnosis are the target population.

Metrics:
- Reduction in ED admissions for patients with a Mental Health and/or substance abuse diagnosis.
- Targeted patients successfully referred to the behavioral health bridge team

Partners:
This is a joint initiative of the Johns Hopkins Regional Partnership**.** The Behavioral Health Bridge team is a shared resource and provides services to the hospitals in the regional partnership.

Sustainability:
Further achievements in PAU will be facilitated by creation of the Behavioral Health Bridge Team through award funding. The benefits can be sustained by savings generated and by building these supports into the total cost of care. Please see JHRP plan for additional detail.

Strategy #4

Embedded RN Case Managers to Improve Prenatal Care and Birth Outcomes

Prenatal care and obstetrics services are an important health service for the community and also represent approximately 10% of all inpatient hospital revenue in the State of Maryland. Therefore, it is critical that Maryland have a number of high-quality, lower-cost obstetrical care providers and birthing hospitals in order for the state to continue to meet its all-payer revenue targets under the new waiver.

Mercy's continued commitment to Obstetrics supports the all-payer model:

- Sixty-nine percent (69%) of obstetrical patients served at Mercy are Medicaid-insured, a critically important and higher-risk population in need of timely prenatal care and additional population health interventions.
- Mercy is Baltimore City's largest birthing hospital delivering nearly 1-in-5 city babies and, combined with its employed physician network, is the largest lower-cost, high-quality obstetrical care provider. Mercy is an essential provider of obstetrical care.
- Obstetrics and Neonatal services account for nearly 14% of Mercy Medical Center's total patient revenue. Obstetrics is hospital's second largest service line program behind only General Medicine.

Mercy has a long-standing practice of community partnerships with Federally Qualified Health Centers. These partnerships are focused on collective learning and initiatives to improve community health. Specifically Mercy maintains active partnerships with Health Care for the Homeless, Family Health Centers of Baltimore, Total Health Care and Park West Medical Center to help manage high risk populations including pregnant women. Our support includes:

- Providing Human Resources services and employing clinical staff on behalf of FQHC's
- Referring patients needing PCP's to FQHC's for primary care and follow up
- Collaborating on ED diversion activities
- Support for shelter population, other related disparity initiatives/subsidies
- Facilitating integrated EMR to foster quality and efficient care

Mercy also currently provides on-site Obstetric services and delivers babies for three FQHC's with disproportionate share of high risk patients (Family Health Centers of Baltimore, Total Health Care and Park West Medical Center.

MHS's goal with this strategy is to reduce low weight babies by embedding a RN case manager at three FQHC sites. The Case Manager will support the PCP/Obstetrician by:

- Ensuring complete and accurate information on Prenatal Risk Assessment (PRA) forms and timely submission to HealthCare Access Maryland and Mercy Medical Center
- Assisting with treatment goals for high risk patients to improve access to care
- Facilitating referrals (e.g. ante-natal diagnostic testing)
- Education regarding pregnancy care, including nutrition and lactation.
- Telephone outreach and home visitation

- Establishing a relationship with individual women and provide motivation to change behavior
- Patient advocacy and liaison between pregnant families and community resources
- Assisting parents to establish a medical home for the newborn as well as all children in the household
- Identifying partner violence and providing support
- Identify issues related to mental health and connect pregnant woman with resources
- Lactation education and support
- Providing group education to pregnant women; topics to include: Pregnancy Care, Signs/Symptoms of Preterm Labor, Preeclampsia, Fetal Well Being, Nutrition, Hospital experience (e.g. Labor & Delivery)

Since each FQHC has multiple sites and multiple clinic days – high risk patients would be centralized in clinics where the case manager is on site.

The Case Manager would jointly report to the local FQHC provider in charge, the Mercy Chairman of Obstetrics and Director of Nursing for Maternal and Child Health at Mercy Medical Center.

Target Population:
High-risk women (teen mother, lack of prenatal care, substance abuse, mental health issue, domestic violence, unstable housing/homelessness, previous infant death, previous preterm birth, low birth weight (<2500 gm) or any other circumstance deemed to be a serious risk for mother or infant by FQHC staff.

Metrics:
Process
- # of patients enrolled per clinic
- # of phone interventions
- # of patients visited at home or facility

Outcome
- Reduce NICU patient days for low birth weight babies.
- Proportion of complete records available in L&D at 36 weeks
- Proportion of patients with completed labs at 36 weeks
- Proportion of patients with positive toxicology screen at presentation
- Proportion of premature and LBW infants

Partners: Total Health Care**,** Family Health Centers of Baltimore and Park West Medical Center, Health Care Access Maryland

Sustainability:
Further achievements in PAU will be facilitated by creation of the Case Managers through award funding. The benefits can be sustained savings generated and by building these supports into the total cost of care.

Strategy #5

Comprehensive Primary Care Strategy – Patient Centered Medical Home (PCMH)
The patient-centered medical home is an innovative primary care model. It is intended to be more patient-centered, team-based, and deliver more coordinated care than the traditional primary care model. The program is designed to improve care quality by improving preventive care, chronic care and helping patients remain healthy (and outside the hospital) The **CareFirst Medicare PCMH pilot** employs nurses working in and across primary care practices. The responsibilities include care management; assisting patients manage their own care and following up on patients at home.

Maryland Family Care primary care physicians at our regional ambulatory care centers participate in the CareFirst PCMH Medicare pilot. In partnership with CareFirst program patient specific care plans were developed and provided care coordination to patients with complex cases, chronic diseases, and other complex diagnoses.

In 2014, MHS panels **saved Medicare $11,273,180** and **saved commercial payers $8,374,506.** MHS regional panels were top performers in this program and the Medicare savings represented more than 40% of the total statewide PCMH savings. However, because MHS's PCMH primary care practice panels are located in Lutherville & Overlea, in closer proximity to other hospitals, much of the PCMH-related utilization savings from avoided hospital admissions and ER visits under GBR accrued to those hospitals, not Mercy Medical Center (particularly UM St. Joseph Medical Center, Greater Baltimore Medical Center, and MedStar Franklin Square-See appendix 2).

Mercy's plan is to continue this successful program (providing it is renewed) at the current sites and with CareFirst approval expand the PCMH Medicare Pilot to primary care physicians located on the Mercy Medical Center downtown campus.

Target Population:
Medicare patients with high risk diagnosis and multiple chronic conditions.

Metrics:
The performance of this program is measured by the CareFirst PCP engagement, patient satisfaction and Outcome Incentive Award scores.

Partners:
CareFirst enables this strategy by supporting the care management staff, the care coordination platform and participating primary care providers.

Sustainability:
Statewide the CFS Medicare Pilot generated significant saving $26M (net of costs) in CY2014. Mercy Family care generated of Medicare savings **$11,273,180.** These net results support the sustainability of the model.

Other Strategy Notes:

Post Acute Care is a key element of Mercy's population health strategy. MHS presently operates a Transitional Care Unit (TCU) comprised of 29 comprehensive care facility beds and is located on the seventh floor of the McAuley Tower on Mercy's campus, 301 St. Paul Street. Baltimore, Maryland. On November 13, 2015 MHS recently received approval from the Maryland Health Care Commission to increase the total number of skilled nursing beds by 3 and the facility will be licensed for a total of 32 skilled nursing facility beds.

The acute care and post acute care TCU program on campus are highly integrated, sharing a common medical staff and nursing staff structure. This high degree of integration and common oversight ensures the highest level of quality, communication, care coordination and progress towards state goals.

Mercy Health Services, through its subsidiary Stella Maris, Inc. also offers skilled nursing, long-term care and home health care services in Baltimore County, Maryland. Stella Maris maintains an affiliation agreement with GBMC Health Care to promote a quality, well coordinated approach to patient care services and works informally with other institutions in the region to achieve the state goals of population health.

APPENDIX 1:

Top Performer—Potentially Avoidable Utilization (PAU): Since January 2013, Mercy Medical Center (MMC) has ranked no less than second for acute care hospitals statewide with the least PAU.

	PAU as a % of Total Charges (All Payer)			
	CY13		*CY14*	
	PAU %	***Statewide Ranking***	**PAU %**	***Statewide Ranking***
Mercy Medical Center	**10.2%**	**2**	**8.6%**	***1***
UMMS	11.1%	5	10.0%	*2*
Johns Hopkins	10.6%	3	10.1%	*3*
G.B.M.C.	11.1%	6	10.2%	*4*
UM St. Joseph	11.9%	7	10.9%	*5*
Anne Arundel	10.9%	4	11.1%	*6*
Garrett County	9.3%	1	11.1%	*7*
Calvert	12.6%	9	11.6%	*8*
Sinai	13.3%	11	11.8%	*9*
McCready	12.6%	10	11.9%	*10*
Statewide Avg	**14.5%**		**13.7%**	

*Includes acute care hospitals
Source : CRISP reporting

APPENDIX 2:

By participating in the CareFirst's PCMH program, MHS primary care physicians saved Medicare $11,273,180 in 2014 and saved commercial $8,374,506

Medicare PCMH Pilot
2014 MHS Performance

	Panel 01	Panel 02			Pilot Total Savings	Pilot Total Savings (Net)
Total Savings	$8,088,468	$3,184,712		Mercy Generated Savings	**$11,273,180**	$26M
				Mercy % of Program Savings	**43%**	
Success Rate for:						
Preventable Admissions	96.7%	97.0%				
Potentially Preventable Readmissions	92.9%	92.6%				
Potentially Preventable ED Use	98.0%	98.6%				

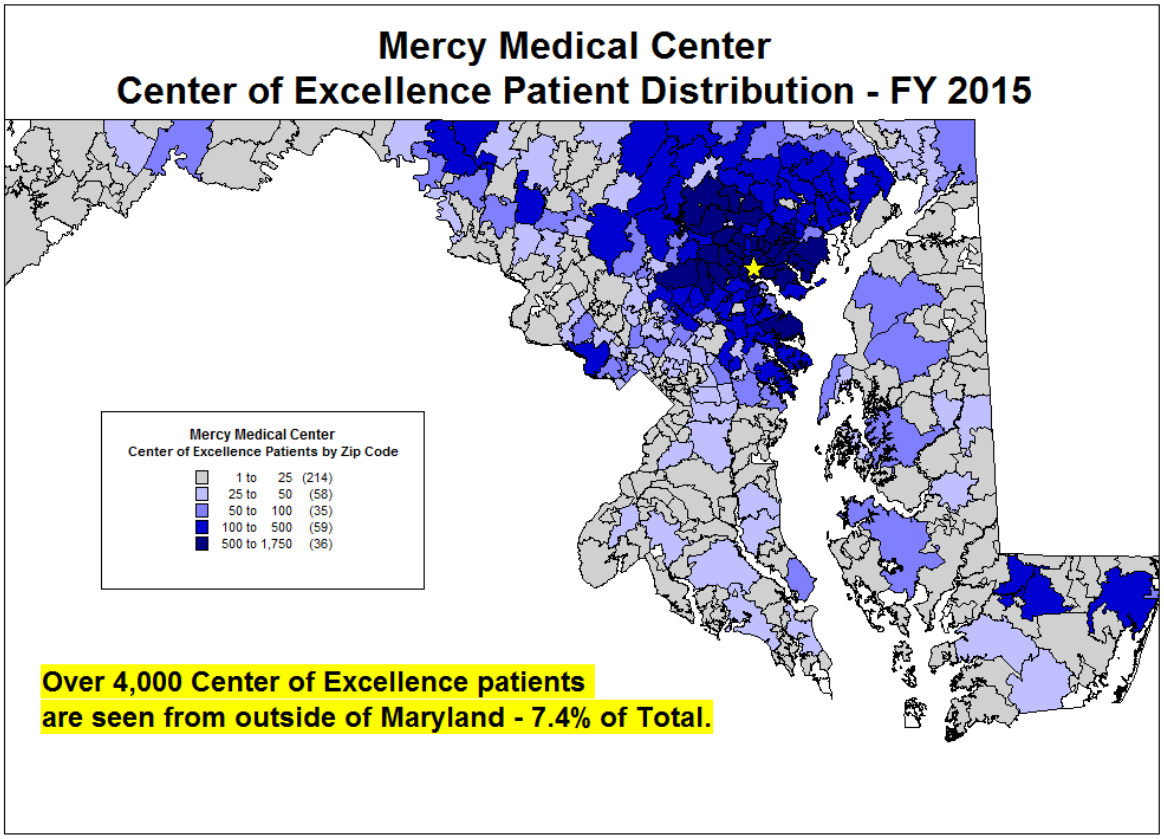
Commercial PCMH
2014 MHS Performance

	Panel 01	Panel 02	Panel 03	Panel 04	Panel 07	Program Total Savings
Total Savings	$946,258	$2,345,815	$1,881,998	$296,632	$2,903,803	$8,374,506
Success Rate for:						
Preventable Admissions	96.7%	99.8%	99.8%	99.7%	99.6%	
Potentially Preventable Readmissions	92.9%	97.0%	98.1%	96.8%	93.7%	
Potentially Preventable ED Use	98.0%	97.8%	97.3%	96.2%	95.8%	

Data Sources - CareFirst PCMH Search Light Reporting
Panel 1 - Overlea Personal Physicians
Panel 2 - Lutherville Personal Physicians
Panel 3 - PCPs from Worthington, Hunt Valley and Canton locations.
Panel 4 - PCPs from Mercy Baltimore Campus.
Panel 7 - PCPs from Mercy Baltimore Campus and Glen Burnie locations.

APPENDIX 3:

Mercy Medical Center generates more than sixty percent (60%) of its revenue from regionally oriented, surgically focused specialty programs (Centers of Excellence). Below is a zip code map showing the breadth of MMC's draw of patients from across Maryland.



Source : Mercy Abstract Data

APPENDIX 4:

Due to Mercy Medical Center's downtown location between other larger hospitals we are not the dominant hospital provider for the targeted population (Medicare high utilizers) in any Baltimore City zip codes. Therefore, Mercy is collaborating with John Hopkins Regional Partnership (JHRP), West Baltimore Collaborative (WBC) and Advanced Health Collaborative (AHC). The map below demonstrates which hospital providers represent the dominant number (>40%) of hospital charges in various Baltimore area zip codes.